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## Summary Proceedings

## Health Information Infrastructure Board Meeting (HIIAB)
## Radisson SeaTac
## Thursday, January 26, 2006, 9:00 a.m. to 4:30 p.m.

**Members Present**
Wendy Carr, V. Marc Droppert, Thomas Fritz , James Hereford, Jeffrey Hummel, Hugh Maloney, David Masuda, Richard Onizuka, Marcus Pierson, Gary Robinson, Karla Pak, standing for Ed Singler, and Alexis Wilson.

**HCA Board Staff and Consultant**
Juan Alaniz, Ruth McIntosh and Dr. William Yasnoff

**Board Members Not Present**
None

**Interested Parties Attending**
Dr. Corrine Bell, United Pacific Care; Tom Byron, Washington State Hospital Association; John Christiansen; Christiansen IT Law; Dan Conlon, Washington State Department of Social and Health Services; Kimberly Creguer, Washington State Department of Information Services; Dr. David Deichert, WANP; Andy Fallat, Foundation for Healthcare Quality; Jim King, Department of Labor and Industries; Steven Macdonald, Washington Department of Health; Helen Nelson, Panorama Care and Rehabilitation; Bob Perna, Washington State Medical Association; Sandy Rominger, The Boeing Company

**Call to Order**
The meeting was called to order at 9:05 a.m. by Chair, V. Marc Droppert.

**Board Meeting Summary**
The meeting summary (minutes) for the December 15, 2005 were enclosed in the January 26, 2006 meeting materials, and will be reviewed to moved, seconded and approved at the February 23, 2006 meeting or before.

**Adoption of the agenda**
All agenda items were adopted. Marc Droppert

**Dr. Steven Labkoff – A National perspective, Trends and Directions**
Dr. Labkoff provided a national overview of trends and directions with HealthIT and EMR adoption as well as an assessment of four regional health information organizations (RHIOs) in the United States. He qualified that Pfizer made no value judgments on any of the models, but that Pfizer's focus and intent was to study and learn from what existed and was operating. He discussed how each of the four communities developed their own unique system approach that reflected their values. Some communities focused on one objective in terms of improvement of patient care, safety, and other means to access to

create sufficiency for physicians. He described the process of trying to identify what a RHIO was, and the challenge of that because there is not one common definition, even looking at other types of RHIOs within other countries, so there was an attempt to come up with ideas to what that meant. Pfizer developed an internal definition for a RHIO, as described in his presentation. Another descriptor was that it had to be "voluntary". It has to have a stable means of self sustainment. It is also not a government entity although government does participate. It is not an entity that existed for competitive advantage of one institution within the RHIO.

Dr. Labkoff provided background on the genesis of various models and the contrasts between them. He provided a brief account of how these community models have worked and integrated key players and stakeholders over time to achieve their current results. He spoke to the trends and implications this has or will have on other models that are in development or that may be contemplated.

He provided observations from these community models on the role of government and stakeholder involvement. Government was in most cases a facilitator or convener. In the case of Washington he expressed that this was probably the role of the Board in providing guidance and framework for decision makers with other organizations and stakeholders interacting with and assisting the Board. Dr. Labkoff states that the presentation material does not completely depict all the activity and stakeholders involved in the activity but that it was incumbent to have everyone represented at the table.

Dr. Labkoff then walked though a high level view of the architecture of the models. There are three types of architecture that were reflected and merged into the study.

- Centralized System which has a single deposit repository center
- Federated Centralized Database System
- Peer-to-Peer Indexed Data Exchange

He provided observations on the structure of some of the models: INHS (Spokane) and eHealthTrust as falling into the category of a centralized repository system; INPC (Indianapolis) into a federated model, and SBCCDE (Santa Barbara) into the federated system as an indexed data exchange model. He commented on benefits and drawbacks of these systems with the context of data sharing. Dr. Labkoff commented that the technology and architectures are not the greatest hurdles, but that politics, sociology, culture, and human factors were greater challenges in bringing institutions together.

Dr. Labkoff concluded with observations about activities at the national level that may be quite applicable for consideration in this work. Some hurdles to overcome within communities are trust and cooperation without shortcuts. Community involvement is

critical for success. A trusted third party may help ease perceptions of competitive threats between organizations. There must be strong leadership from the community to deliver a higher quality for health care.

It seems more research is needed in several key areas for RHIOs, from testing and evaluating the financial incentives that needs to support the health information technology, and linking multiple sources in different ways, e.g. specialist, labs, and hospitals which allows shared information between two or more different RHIOs.

There is a need to further examine the cost for change management that is associated with the training and workflow needs. Dr. Labkoff's presentation can be accessed at: **Dr. Steven LabkoffPresentation\RHIODeckforSeattle.pdf**

**Confirming the charge: Moving from the Interim Report**

Steve Hill, Administrator of the Washington State Health Care Authority (HCA) greeted the Board and praised them on the outstanding and the continued good works they are doing as well as Marc Droppert for his service in the position of Chair for this board.

Steve addressed the Board, Distinguish Guests, and Interested Parties with a perspective on what he envisioned as the work of the Board.

He provided background and commentary on other discussions he has had with other groups in the role assigned to him by the Governor to help reign in the escalating health care costs and a need to change the health care system.

He outlined and spoke to the Governor's five point health agenda. (1) Is that we want the state to have the ability to help technology assessments and pay for treatments that work. (2) We want to do more with the chronic (5/50) population, using both care management and also preventive modeling. (3) We must have more transparency in the health care system, with the understanding of providers delivering quality and efficiency. (4) We want better prevention and wellness with state beneficiaries. (5) We believe one way to motivate the work and making changes to the system and improving quality and efficiency, and a way to affect the other four objectives is through health information technology. The work of the HIIAB is central to the Governor's health strategy.

Steve Hill opened for comments and continued with his opinions of what policy makers expect from this group. Steve provided a sketch as a visual of what he envisions as the steps to consider in development of a strategy and recommendations. Steve Hill Strategy Plan -HIIAB Mtg. 012606.pdf

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**Recap: Assessing Potential Solutions and Various Review Criteria**

Marc Droppert facilitated this discussion with the Board. There was lengthy discussion and questions regarding potential models with their advantages and disadvantages, and a suggestion to reexamine potential model solution architecture. Some Board members also addressed process issues on how to determine the extent of the criteria to be utilized in assessing solutions. He outlined an approach in order to address and move into a next step in the assessment process. He proposed this outline to the group to harness the discussion.

- Analysis – current definition -vs- the target definition
- Reexamine architecture
- Business Model
    - What is it? What do we deliver; is it evolutionary?
    - Mandatory; Voluntary – Mandatory (moving to voluntary)
    - Who owns the data?
    - Who pays? Startup vs. Sustaining
    - Role of the State
      -Create the buy in component
- Structure/ Governance

The HIIAB continued to make comments from Steve Hill's earlier talk as it applied to the assessment discussion.

Marc asked for other feedback from the Board to consider for assignments for the next scheduled HIIAB in February 2006. No additional comments or suggestions from the group.

**Interested Parties Q & A - Recap: Assessing Potential Solutions and Various Review Criteria**

**Andy Fallat - Foundation for Healthcare Quality**

He commented that the clarifications and talk from Steve Hill was inspiring and addressed what he also agreed was higher quality health care for consumers. "What is good for the community and what is good for patient." He further commented that there were good health care systems represented in the room such as INHS, Group Health Cooperative, and Multi-Care Hospital. He wondered if insurance companies might be part of the problem, and if they could be engaged (in working towards a solution).

**Dan Colon- Department of Social and Health Services**

Mr. Colon commented that the system should reward quality care and be able to change the way we care and provide physician reimbursement. Insurers and providers have gone around the system. There are systems in place that might work but are not perceived to be more than cost saving strategies not quality efforts, or ways to improve care and provide

more efficient treatment. He encouraged the Board to consider existing efforts aimed at improving the quality of care of the chronically ill and build on that momentum. He made some further recommendations to the Board on how to leverage existing organizational structures to affect the type of needed change and how to appropriately use the role of government to develop policy.

**Bob Perna**
Mr. Perna addressed the Board and asked whether there was some evolution in thinking about the end result the Board was after. He mentioned that a question which came up at the HIISAC meeting was around the issue and focus really being on interoperability. Is interoperability the goal or is the Board working towards a grander model or scheme?

**Tom Bryon-Washington State Hospital Association**
He commended the HIIAB for the decision to reassess the direction and provide a more transparent process. He also stated that he wished Steve Hill had been at the first meeting of the HIIAB. He provided recommendations on pursuing a more focused and simple strategy. (Other comments made by Mr. Byron were inaudible on the tape).

**Jim King - Department of Labor and Industries (L&I)**
He thanked the Board for taking a step back. He commented that part of the difficulties he saw were how state agencies actually keep up (with expenditures). He explained that L&I deals with premiums for a base budget and have to then make sure there are enough dollars in order to spend on IT. One of the things L&I is attempting is to reduce the administration burden on the individual practitioners and the hospitals etc. He commented that the problem they have with electronic health records is that they are not ready for it. They cannot accept the electronic information out of the PHR yet. When they visited Group Health, they learned that Group Health had hired an extra person to make screen prints for L & I so that information could be provided. It showed me that we will just add administration burden, unless there was a change in how they accepted information. He recommended that as the Board transitioned the target (goal), that the Board consider and include that state agencies change the way they deal with information as well, and that they can not stay where they are.

**Considering Alternatives**
The Board will consider suggestion Steve Hill addressed to the group and the comments from the interested parties and the public. Dr. Yasnoff proposed that the Board revisit the principle language drafted in the report, Overall Goals All Info Available - WYasnoff12606.pdf and to include patient participation.

**Review/Discussion of Potential Solutions and Attributes**

The HIIAB continued to deliberate on questions for the solution steps and on what the solution or desired state would be articulated. Alexis Wilson referred back to the discussion from Steve Hill about how to look at this from a broader perspective than just as IT.

Marc proposed that a sub-group be develop and come back with options to what the architecture might look like based on what is currently in place now. The Board members will be Jeff Hummel, Tom Fritz, Gary Robinson, and Marc Pierson. The Board Chair suggested to the sub-group that they consider administrative features which might not be clinically based but that provide efficiencies that help drive the economics such as eligibility and third party information that will help provider participation and assist in cross over functions.

**Interested Parties and Public Comment**
**David Diechert, Resident, Bastyr Center for Natural Health**
"Following Steve Hill's presentation, there was discussion surrounding that action steps required to take us from where we are today to the health care system (as envisioned by the board) of tomorrow. My concern is that during this conversation it appeared as if we were envisioning the same (current) health care system enhanced through the leverage of HIT. While this does hold the potential to improve the health care system, I believe that in order to be successful we need to go deeper.

As you know, there is literature detailing that the current plight of the health care system, at least in part, is due patients with chronic health conditions utilizing a system designed to deliver acute care. Furthermore, patients needing care for chronic conditions not only consume a significant amount of health care resources, but also represent a population of patients that will continue to increase in the foreseeable future.

As such, the board's task becomes not only applying HIT within the constructs of the current health care system, but to design and envision HIT as a way to capture, utilize, and streamline patient data in order to facilitate and enhance the management of chronic conditions. For example, diabetic patients are encouraged to monitor glucose levels, change their diet and lose weight; asthma patients are encouraged to take daily peak flow readings and adjust their treatment accordingly; and hypertension patients are encouraged to take regular blood pressure readings. This results in chronological patient data, generated by the patient that becomes useful in the management of their disease. In today's health care system, there is no efficient way to incorporate this information into a patient's chart in a meaningful way (i.e. utilizing trends to adjust treatments). Furthermore, there is currently no efficient way for the team of health care providers commonly needed to manage chronic conditions (GP, internist, cardiologist, naturopath etc) to share this

information and make informed decisions as a group. This board has been given the green light to brainstorm how to change the health care system to organize new types of patient information and thus maximize its ability to treat chronic disease. This will require thinking outside of the box to envision how to leverage HIT to manage patient data for conditions that require several different types of practitioners working with patients for extended periods of time."

**Tom Bryon, Washington State Hospital Association**

Mr. Byron noted that in the preliminary discussion of models he did not see where the Northwest Physician's Network model would fit under. He did not see what models in the preliminary discussions would fit the models presented by Dr. Matta, Columbia Valley, and other presenters of examples of WA state activities. Mr. Byron cautioned to look at the issues from a small business and network perspective. He made specific recommendations to ensure a more thorough assessment of models and made recommendations on the role of the consultant to avoid misperceptions and assure a more transparent and fuller dialogue. He provided examples and scenarios depicting the challenges of adoption that need to be addressed before moving to a bigger solution and EMRs.

**Dr. Corrine Bell, United Pacific Care**

The community collaboration needs to include and make the necessary linkages to surveillance. The early detection is also a prime source in helping in this area. (Other comments made by Dr. Bell were inaudible). .

**Continue - Review/Discussion of Potential Solutions and Attributes**

The HIIAB will resume further discussion on "who will pay"? The Board concluded that it would be helpful to have some knowledge about this question from providers and consumers. There is national data on the subject, but the Board determined that it would be beneficial to develop and conduct a provider and consumer survey to gauge the level of support for such a concept. There was also discussion on whether employers were willing to pay.

**Wrap Up/Assignments/Adjournment**

Richard Onizuka will consult with employers/purchasers and invite them to a Board meeting so that they can provide the HIIAB with their perspective on HealthIT and EMR adoption and address questions on "who should pay?" Jeff Hummel and other HIIAB member will report on their architecture sub-group. Bob Perna on behalf of Washington State Medical Association and Dr. Yasnoff will work together in identifying what would be required for a patient and provider survey, and will report back the Board. Juan Alaniz

will facilitate getting Indianapolis data tables from Mark Geist with the assistance of Mark Pierson.

With no further business and with assignments confirmed by Juan Alaniz, the Board was adjourned by Chair, Marc Droppert at 4:15 P.M. The next meeting will be held at the Clarion Hotel in SeaTac on Thursday, February 26, 2006

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